

Care of the Deceased Patient Policy

Issue Date	Review Date	Version
July 2018	July 2021	V5

Purpose

To set out the Trust's arrangements for the provision of the Bereavement Service, which is in place to provide information, guidance and support to our patients, bereaved relatives, carers and members of the public.

To ensure that all staff who have significant contact with deceased patients and their families have access to policies / procedures to enable them to provide appropriately high standards of care.

Who should read this document?

Trustwide

Key Messages

The Bereavement Team offers practical and emotional support to the immediate family or next of kin of anyone who dies while a patient of the Trust, together with anyone who is bereaved and connected with the Trust.

This includes working with medical, midwifery and nursing colleagues to ensure prompt completion of all the necessary paperwork after a death, as well as explaining to the bereaved relatives or carers how to register a death and how to find a funeral director, or arrange a funeral without a funeral director.

The Bereavement Team will work closely with the Coroner's Service, the Plymouth Register Office and local funeral directors to ensure bereaved relatives have access to all the information and services they require. When necessary the Bereavement Team will refer families to the appropriate Coroner's Officer.

Core accountabilities

Owner	Patient Experience & Engagement Manager Patient Services Manager Bereavement Officer Trust Chaplain
Review	Patient Experience Committee
Ratification	Chief Nurse
Dissemination (Raising Awareness)	Patient Services Manager
Compliance	Patient Experience Committee

Links to other policies and procedures

Complaints Standard Operating Procedure
Management of Patients Property
Interpreting & Translation Policy
Handling of Cadavers Policy
Cardiopulmonary Resuscitation (CPR) Decision Policy
Resuscitation Policy
End of Life Care in Hospitals Standard Operating Procedure, Ver 3, May 16
Hospital Bereavement APN

Version History

V3.1	25 May 2010	Clinical Governance Steering Group
V3.2	27 July 2011	Renamed policy to Care of Deceased Patient Policy from Deceased patient Policy
V4	18 August 2014	Revised policy to reflect current practice and new format
V5	July 2018	Revised policy to include deaths in the outpatient setting.

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

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1 Introduction

The aim of this policy is to ensure that all staff who have significant contact with deceased patients and their families and carers have access to the necessary information and guidance to enable them to provide appropriately high standards of care.

Some deaths in hospital will be sudden or unexpected. The Resuscitation Policy and procedures should be followed in cases of cardio-respiratory arrest. Ensure the patient has the right to make the choice to be or not to be visited / supported by any chaplain, other religious leader, other spiritual carer or faith community representative.

This policy applies to all hospital staff that maintain contact with patients / carers at the end of life.

2 Purpose

This policy covers an important aspect of holistic care; that of last offices and details the Trust's Bereavement Service arrangements. Supplementary information may be obtained by consulting the latest version of the Marsden Manual of Clinical Nursing Procedures and the University Hospitals Plymouth NHS Trust Infection Control Team Handling of Cadavers Policy.

- 2.1. There are specific procedures for last offices and the support of bereaved relatives in the cases of death of infants or children which should be followed (refer to appendix 1).
- 2.2. The dying patient should have their care during the last few days or hours of life planned in accordance with their own wishes and those of their family / significant others.
- 2.3. Where death can be expected in hospital, the clinical team should seek advice from the medical and nursing team and if necessary the specialist palliative care team re symptom control.
- 2.4. Care of the dying/deceased patient should at all times be respectful of the need for patient/carer privacy and dignity. Every effort should be made by everyone involved, to adhere to the patient's known wishes and beliefs, and to have regard to any individual needs.
- 2.5. Regard to the possible sensitivities of any particular individual or group must be uppermost in our minds, and care taken to avoid offence being caused to anyone's beliefs or values. Similarly, all strands of equality and diversity should be recognised and respected. Specific guidance for major faith-groups can be found on Staffnet at: [Staffnet - Pastoral Spiritual Care Guidance - Multi Faiths](#)
- 2.6. Care with dignity does not finish when a patient dies. Administering last offices is the final demonstration of respectful, sensitive care given to a patient and gives a message to family / other patients that care continues after death. Last offices focus

on the fulfilment of the patient's personal, cultural or religious beliefs as well as health, safety and legal requirements.

- 2.7. The transportation of the deceased patient is a particularly sensitive situation, (see section 6) of this policy which includes guidance on this matter in general, including particular considerations surrounding the movement of bariatric patients and those patients who die in outpatient settings.

3 Before Death – 'End of Life Care'

- 3.1 Patients who are thought to be dying should be reviewed by the medical and nursing staff to ensure appropriate end of life care is given. Patient's resuscitation status must be identified, recorded and communicated to all team members in line with the Trust Resuscitation Policy.
- 3.2 Cardiology must be informed if the patient has an implanted cardioverter defibrillator (ICD); the presence of this, or any other sensitive device, must be documented on the front of the patient's records (refer to appendix 2).
- 3.3 A dying patient's comfort, privacy and dignity should be maintained at all times. The patient's preferred priorities for care should be ascertained and efforts made to meet these wherever possible. All such discussions must be documented in the patient's records.
- 3.4 A single side room should be offered to a dying patient and their family / significant others wherever possible. This may not always be possible, due to the needs of other patients to be nursed as a priority in a side-room.
- 3.5 The family / significant others must be kept informed of patient's condition, prognosis and care decisions, with the patient's permission.
- 3.6 Family / significant others telephone numbers and relationship to patient should be recorded including agreed times to contact in case of impending death /death (i.e. at any time, not at night time).
- 3.7 Every effort should be made to provide advice about short-term accommodation within and near the hospital for family / carers wishing to stay.
- 3.8 The wishes of patients and their families / carers or in particular cases where a patient has a Lasting Power of Attorney in place for health, regarding any specific actions to be taken at time of impending death, at death or after death should be ascertained and documented and the team made aware of these e.g. details of advanced directives (living wills), involvement of spiritual support, religious and / or cultural requirements (ceremonial washing, mode of dress), organ / tissue donation (NHS Organ Donor Register), bequeathing bodies (Bristol), cremation, burial.
- 3.9 Where identified by the patient, family or carer a relevant spiritual/religious representative should be contacted to offer support and/or religious procedures prior to death. These may be contacted direct, or via the Department of Pastoral & Spiritual Care (ext 55255) or during out of hours bleep the on-call chaplain.

- 3.10 Organ donation most commonly occurs in intensive care setting, but tissue donation (e.g. eye and heart valves) is possible for many individuals. It is essential for staff to establish if the patient has previously expressed the wish to be a donor; if the patient is on the NHS Organ Donor register or carries a donor card. In such circumstances there is a legal consent in line with the Human Tissue Act of 2004 (June 2011), and the next of kin cannot in law overturn that consent. However the law also recognises that if a family is absolutely against donation, then it may not be appropriate to pursue further.

For all deaths, The NHS Organ Donor Register should be checked by calling - 01179 757575. The Donor Transplant Co-ordinator should be informed (radio page via switchboard) if the patient is registered, carried a donor card or the family agree to donation.

4 Confirmation of Death

- 4.1 The appropriate medical staff must be informed when a death occurs. Death must be verified by a medical practitioner. In the case where an expected death has been documented, an appropriately designated senior nurse from the Acute Care Team may confirm death, to allow last offices to be undertaken – this must be verified by a medical practitioner in order to complete death certificate at a later time.
- 4.2 In the case of an unexpected death a medical practitioner must be called immediately to attend and verify death. Consideration should be given to the need for referral to the Coroner (see Coroner’s guidance included as part of appendix 4).
- 4.3 Details of death must be recorded in the patient’s record/clinical pathway before the deceased’s body can be transferred to the mortuary.
- 4.4 Tubes or lines must be left in situ and spiggoted or taped e.g. nasogastric, drainage tubes, and intravenous cannulae, or any other equipment associated with the patient’s welfare. These may provide important information at autopsy, refer to appendix 7 for further detail. Guidelines for the Handling of Cadavers Policy held on staffnet will also provide further information [Guideline for Handling Cadavers](#).
- 4.5 Staff should ensure that all who need to know about the death are quickly and sensitively informed, this includes family /significant others, staff involved in patient’s care and other patients on the ward. Staff should recognise the impact a death may have on other patients.
- 4.6 Relevant spiritual representative(s) should be contacted, as requested prior to death, to undertake religious rites as appropriate or as identified for family support.

5 Last Offices Guidance

- 5.1 Last Offices should only be carried out following verification of death and recording of this. They should be carried out in an unhurried but timely manner, preserving the dignity of the patient at all times refer to appendix 1.
- 5.2 Guidelines for the Handling of Cadavers should be consulted for general procedures, infection control advice and guidance on medical devices. For those

patients for whom there is known or suspected infection, an Infection Control Notification Form must be completed.

- 5.3 Any wishes for organ donation should be discussed with the deceased family (see Section 3.10 above) University Hospitals Plymouth Specialist nurses in Organ Donation can be contacted 24 hrs a day through the hospital switchboard.
- 5.4 Where family / significant others wish to be involved in last offices staff should offer support and the opportunity to enable this to happen. Details of all family / significant others involvement and wishes need to be clearly documented in the patient's records.
- 5.5 In the rare occasion when a family wish to take the deceased home, via Funeral Directors, rather than to the hospital mortuary, the Bereavement Office should be contacted for advice; out-of-hours the on-call manager and duty Mortuary Technician should be contacted.
- 5.6 Spiritual guidance for Last Offices should be followed for different religious faiths (see Spiritual Advice Guidance and Marsden Manual of Clinical Nursing Procedures).
- 5.7 In the case of prisoners who die within the hospital, certain special procedures, agreed with HM Prison Service, need to be followed. All prisoners who die in hospital must be reported to the Coroner. Those referring to End of Life Care can be found in the Trust's End of Life Care in Hospitals Standard Operating Procedure.
- 5.8 Care of the prisoner's body will be as set out in the Trusts' Last Offices, appendix 1. The escorting prison officer will escort the body to the mortuary until they receive a receipt for the body. The decision to inform the relatives will be determined by the Governor as the official next of kin. University Hospitals Plymouth NHS Trust staff should not inform relatives, friends etc.

6 Last Offices Guidance- Outpatient Setting

- 6.1 The patient's death must be verified before the process for Last Offices begins. If the patient is an inpatient, this must be done by a member of the clinical team on the ward who should be asked to attend immediately. If the patient is an outpatient, this will be done by the clinician attending the resus call.
- 6.2 Overall responsibility for managing the patient's body and the process for last offices must sit with a doctor or nurse. However, a member of the team from the department in which the death has occurred must remain in attendance until the body is transferred to the mortuary.
- 6.3 Monday to Friday between 9-5pm, there is support available from the Resuscitation Officers. Out of hours the Senior Nurse on-call (355) would need to be contacted and informed of the patient's death. If the patient is an inpatient then clinical staff on the ward from which the patient has come from will be asked to assist with this but if the patient is an outpatient, this will be led by the resus team and a nurse nominated by the senior nurse on-call. All relevant staff who are required to provide support for last offices must be in attendance within 30 minutes.

- 6.4 A bereavement box must be kept in all outpatient areas and the contents must include shrouding to wrap the body, PALS and Bereavement leaflets, step by step guide for managing deceased patient within an outpatient area, property bags, property book and deceased tags
- 6.5 If relatives wish to see the patient's body after they have passed away this can be arranged to take place within the mortuary viewing suite. Guidance on who the relatives need to contact to arrange this can be found in the relatives bereavement booklet.
- 6.6 If relatives are in attendance at the time of the arrest, they can remain with the patient but they must not be left unsupervised. Discussion and support for the family will be provided by the clinical teams in attendance.
- 6.7 If next of kin are not in attendance or within the hospital, either the clinician involved in the arrest or consultant in the area need to contact next of kin to inform them the patient has passed away. If they cannot be contacted, the police need to be notified and they will inform the next of kin.
- 6.8 Staff involved in the incident should be offered support following the event and this can be provided by seniors within the team or the Resuscitation Officers.
- 6.9 If an arrest occurs outside of the main hospital building but is onsite (i.e. PET/CT scanner) the Resuscitation Team should be called however, if the patient dies, the last offices process does not apply. An ambulance should be called to collect the body and they will transfer them directly to the mortuary.
- 6.10 Under no circumstances should the patient be transferred to any other area within the hospital after they have passed away. If a patient deteriorates during transfer, they should be taken to the nearest clinical area for assistance. If the patient passes away within that area Last Offices should take place there before they are taken to the mortuary.
- 6.11 Each outpatient area should have a local policy for managing deceased patients, including specific arrangements such as where would the body be kept.

7 Procedures following Last Offices

- 7.1 All those involved in the care of a deceased person should respect the dignity, privacy and confidentiality of the person who has died and ensure their body is secure at all times.
- 7.2 The deceased should be moved to the mortuary once the death has been verified and family / significant others have had time say their goodbyes. Unnecessary delays should be avoided.
- 7.3 The deceased should always be moved to the mortuary in a concealment trolley, and never using subterfuges which leave the face of the patient exposed to public gaze. Should the standard concealment trolley not be appropriate use of a bariatric concealment trolley should be considered.

- 7.4 Relatives present at the time of death or shortly after death should be offered emotional support and given a copy of the hospital bereavement booklet 'Help for Bereaved Relatives' and the Department of Work and Pensions Booklet 'What to do after death in England and Wales' (D49).
- 7.5 Details of the patient's death need to be registered on the hospital Information Patient Management system (IPMs) and the patient's GP notified of the death (see APN.PRO.111.6 Notification of Death, August 2017 - [APN - Notification of Death Staff Net](#)).
- 7.6 A medical cause of death certificate and cremation form must be completed by a medical practitioner who has treated the patient. This must be done as soon as possible after death, **and no later than the next working day**. In all cases the necessary forms must be completed before the deceased can be removed from the hospital, delay in this matter can be most distressing to bereaved families, and completion is a high priority.
- 7.7 It is the medical practitioner's responsibility to contact the coroner if this is necessary (please refer to guidance on appendix 4).
- 7.8 If a hospital post mortem is required the medical practitioner needs to obtain the written consent of the next of kin / family, including any limitations and tissue requirements before this can proceed. A member of the Bereavement or Patient Services team should accompany the doctor to witness consent to hospital post mortem. The necessary paper-work, including a signed request form with patient history, reason for request is only available from the Bereavement Office. Please refer to the Trust policy – Consent to Examination and Treatment, which details the process for obtaining consent for an autopsy [Consent to Treatment & Examination Policy](#).
- 7.9 The bereavement team must be notified of the death as soon as possible and at least by 10.00 hrs the next working day, as the family will be contacting the office after that (see appendix 5).
- 7.10 All of the deceased patient's property must be entered into the property book. The medical records, medical cause of death certificate and property should be taken to the Bereavement Office as soon as possible (see APN.PRO.111.6 Notification of Death, August 2017).
- 7.11 The deceased's family / significant other should be asked to contact the Bereavement Office by telephone after 10.00hrs on the next working day (see appendix 5).
- 7.12 Family wishing to see the deceased should be given the opportunity to do so in the Sir Jules Thorne viewing suite on level 4. Relatives should be advised an appointment needs to be made for them to see the deceased through the Bereavement Team; during out-of-hours this can be arranged with the on-call mortuary technician. Please note viewings after 8pm are in extreme circumstances only and should be discouraged. Families should be made aware that the Mortuary Team are not permitted to alter the appearance beyond closing the eyes and brushing hair, therefore bodies will be viewed as is.

- 7.13 Wherever possible, hospital viewings should be during office hours. Ward staff should contact the Bereavement Team (ext. 39492 or 39473) who will make the arrangements. The bereavement officer will usually accompany a family for a viewing during office hours unless it is more appropriate for a member of ward staff to undertake this task. When viewing is requested out-of-hours, ward staff should ring switchboard who will contact the duty mortuary technician to arrange this. The relative should be accompanied by a member of ward staff, the department of pastoral and spiritual care or duty senior nurse.
- 7.14 Families should also be advised that viewings can be arranged at their chosen funeral director where the deceased will have been prepared for viewing. The family should contact their funeral director to make arrangements.
- 7.15 If a death has been referred to the coroner, opportunities for the family to see and care for the body may be restricted. Information from the coroner's office (see coroner's guidance including as part of appendix 4) and close liaison with the family is therefore important in this respect.
- 7.16 Where the Coroner is involved family viewings are overseen by the Coroners officer unless by prior arrangement with the bereavement team.

8 Bereavement Card

- 8.1 It is recognised that dealing with the loss of a close friend or family member may be one of the hardest challenges some of us face and although death is a natural part of life many of us still can be overwhelmed by shock and confusion. In this state it is well known that we do not take in all information given to us and our ability to think rationally can be impaired. In this environment it is not surprising that many forget to ask questions.
- 8.2 The bereavement card process is in place to offer bereaved relatives an opportunity to speak with the clinicians involved and take time to discuss the care the deceased patient received while in hospital. Bereavement Card process is attached as Annex 7.
- 8.3 At the end of each week, the list of deceased patients occurring during the previous week are reviewed. Further checks are completed against our existing complaints, incidents or coroners cases to confirm there are no on-going investigations or existing communications in place. Once this has been confirmed, cards are sent to the registered next of kin, one week after the date of death.
- 8.4 Families are offered the opportunity to meet with clinicians involved in the care of their loved ones and asked to contact the Bereavement Team if they wish to take up the invitation. Once contact has been made the Bereavement Team will liaise with the relevant matron to lead the ongoing communication and ensure the correct staff are involved in dealing with any queries they family may have.

9 Staff Training

All staff who have significant contact with dying patients and / or bereaved relatives should have available training and learning opportunities to enable them to develop

accurate knowledge of policy and procedures and an appropriate level of knowledge and understanding of death, bereavement and loss.

Training must include safe handling of deceased patients as detailed in the guidelines for Handling of Cadavers Policy.

Training in emotional support and breaking bad news should also be included.

10 Overall Responsibility for the Document

Head of Pastoral and Spiritual Care and Patient Experience & Engagement Manager.

11 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Patient Experience Committee and ratified by the Chief Nurse.

Non-significant amendments to this document may be made, under delegated authority from the Chief Nurse, by the nominated owner. These must be ratified by the Chief Nurse.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

12 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Chief Nurse and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

13 Monitoring Compliance and Effectiveness

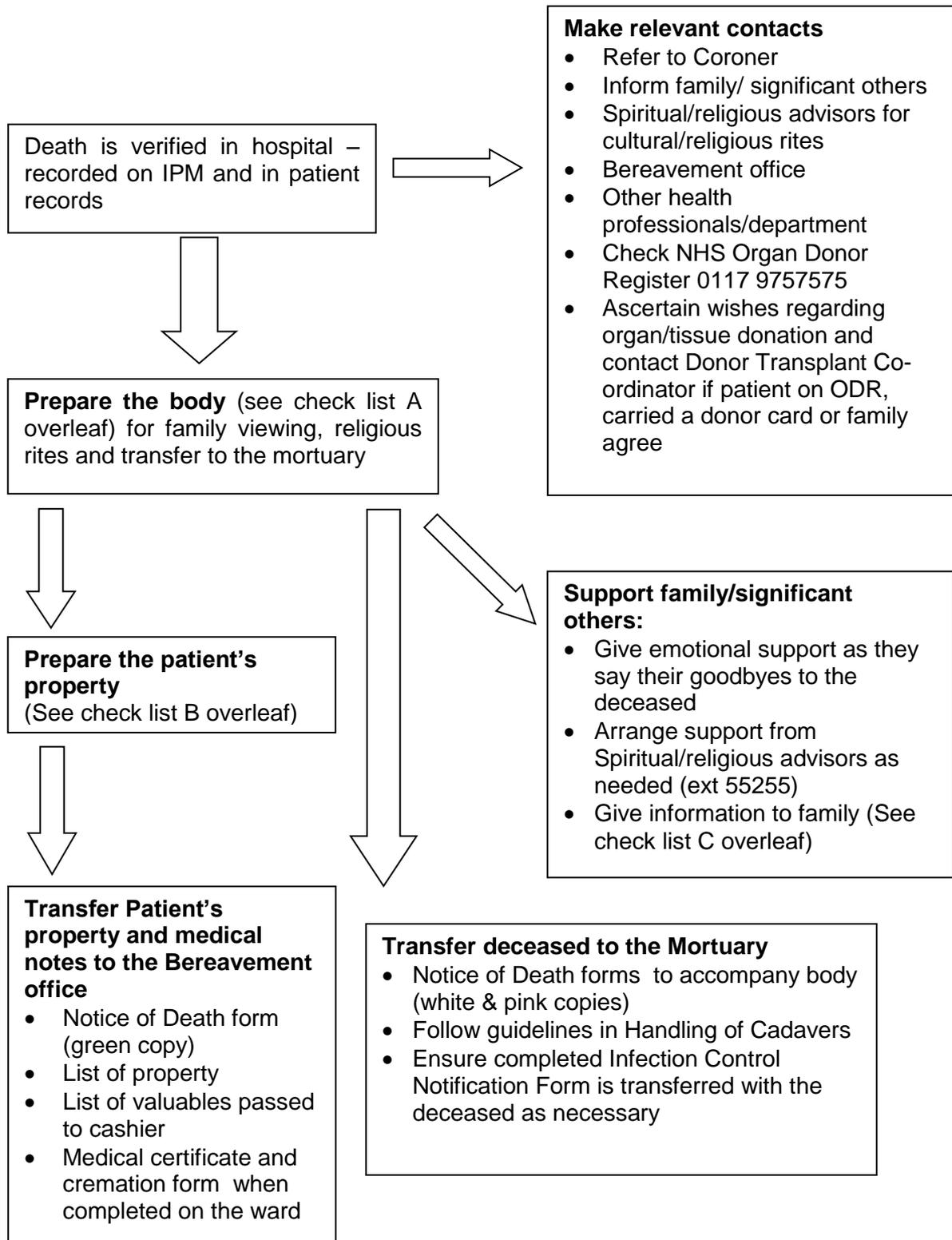
The Bereavement Office will monitor the number of deaths and maintain records detailing each death and subsequent arrangements.

Where breaches of this guidance are identified, this will be reported to the Medical Director and where necessary Coroner.

Each death in the hospital will be subject to a mortality review whereby the clinical governance lead from the relevant speciality will review the cause of death and a number of other factors.

10 References and Associated Documentation

- BROOME, A. & LLEWELYN, S. (eds) (1995). Health Psychology: Processes and Applications
(2nd edition) London: Chapman & Hall
- DEPARTMENT OF HEALTH (2003). Essence of Care, Guidance and Benchmarks April 2003.
- DEPARTMENT OF HEALTH (2005) – When a Patient Dies
- Dougherty, L. Lister, S. (2004) The Royal Marsden Hospital Manual of Clinical Nursing Procedures, Blackwell Publishing. London
- NEARNY, L. (1998i). Last Offices - 1 Nursing Times, vol.94, no. 26, July 1st.
- NEARNY, L. (1998ii). Last Offices - 2 Nursing Times, vol.94, no. 27, July 8th
- NEARNY, L. (1998iii). Last Offices - 1 Nursing Times, vol.94, no. 28, July 15th.
- NURSING AND MIDWIFERY COUNCIL (2005). Guidelines for Records and Record Keeping.
- UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST INFECTION CONTROL TEAM (2013) – Guidelines for Handling of Cadavers
- UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST (2012) – Trust Wide Resuscitation Policy
[Trust wide Resuscitation Policy - Staffnet](#)
- Plymouth Staffnet website:
[Staffnet - The Intranet for University Hospitals Plymouth NHS Trust > Document Library > Trust Documents](#)
- ROYAL MARSDEN HOSPITAL (2013) – Clinical Nursing Procedures, Chapter 21



NB: THIS AND THE FOLLOWING APPENDICES ARE DESIGNED TO BE PHOTO-COPIED AND USED SEPARATELY FROM THE MAIN POLICY DOCUMENT.

CHECK LISTS FOR LAST OFFICES

Prepare the body - Check list A

- Follow guidance in Guidelines for Handling of Cadavers
- Ensure dignity, respect and security of deceased at all times
- Position body on back with support of one pillow
- Close eyelids
- Insert dentures and close mouth – record in patient's notes
- Remove all mechanical/electrical devices and plug tubes and drains
- Record any Implanted cardiac defibrillators in situ – to alert to the mortuary staff
- Where necessary, leave cannulae, catheters, wound dressings etc in situ record in patient's notes, using body map if appropriate.
- Ensure all tubes are spiggoted and wounds dressed – to avoid leakage: record in notes.
- Wash skin, clean mouth, shave face and comb hair – unless specific religious preparation of the body is required (refer to Marsden Manual if in doubt)
- Dress deceased in clothes/nightwear/ shroud according to family wishes
- Remove jewellery, unless requested by family to be left in place – record any jewellery left on the patient and secure with tape
- Fit Patient ID bracelets to wrist and ankle – providing patient ID details and details of death; if existing ID bracelet on wrist has become illegible, this should be replaced.
- Cover the patient with appropriate bedding
- Remove all other linen, equipment, belongings etc from the bedside
- Once the family have attended the deceased, prepare for transfer to the mortuary
- Wrap the deceased in a clean sheet and secure with tape
- Place the deceased in a body bag if leakage of body fluids is likely
- Complete body identification form(s) and secure to the sheet or body bag in the chest area
- Record all care given and any clinical devices remaining in the body – using body map if relevant.

Prepare the patient's property - Check List B

- List all patient's property – checking contents with second person
- Record all valuables in the Property book, including any jewellery removed from the deceased – to be logged with the Cashier for safekeeping
- Valuables and/or property removed by the family should be recorded at the time
- Place property in patient's bag or Hospital Property bag – carefully and tidily
- Soiled clothing returned to family from the ward needs to be in an alginate bag and labelled

Information to family/relatives/significant others - Check List C

- Consider the need for Communication Supports (ie, signer, translators)
- Details of any coroner or hospital post-mortem needed (Drs to discuss)
- Information re Bereavement office opening hours
- Arrangements for viewing the body at a later stage at the Sir Jules Thorne viewing suite on Level 04 - viewing arranged through the Bereavement office
- Ascertain any known wishes regarding organ and/or tissue donation- check NHS Organ Donor Register 01179757575 - refer to Donor Transplant Co-ordinator if registered, carried a Donor Card or family agree
- Trust and DWP Information booklets to be given to family
- Information and discussions held with the family must be recorded in the Patient's medical records

1. The End of Life Care Standard Operating Procedure gives advice regarding patients with Implanted Cardiac Defibrillators or ICDs. An increasing number of patients are having ICDs implanted particularly for the treatment of heart failure. Special precautions need to be taken with these devices.
2. If a patient is expected to die within weeks from a life limiting disease it is advisable to have the ICD deactivated to prevent it firing inappropriately. An ICD can alter unstable cardiac rhythms and deprive a terminally ill patient of a timely, natural death.
3. Ideally a discussion should take place between the patient, family or significant others, and the medical team / GP. Decision will need to be made about the management of the illness, the relevance of the defibrillator and the possibility of deactivation of the device In order to avoid unpleasant symptoms. ICD discharges can be physically and emotionally distressing for patients.
4. The cardiologists opinion should be sought. If deactivation is felt appropriate the cardiologist will notify the cardiac physiologist in writing. The patient / family will then be contacted to arrange a suitable time for deactivating the device. A programmer is needed to deactivate the ICD. There is currently no domiciliary deactivation service in the south west.
5. ICD devices must be deactivated and removed before a patient is cremated (see Plymouth Hospitals NHS Procedure 5020). It is vital that mortuary staff are aware of the presence of an ICD as an active unit can give a mortuary technician removing it an unpleasant shock. The presence of an ICD should be clearly marked on the front of patients medical records. Ordinary pacemakers do not need to be deactivated prior to death, but must like ICDs be removed prior to cremation.
6. Bereavement Administrator is required to obtain written consent for removal of ICD or pacemaker from patient's family.

For further advice please contact:

7. Cardiology Department, University Hospitals Plymouth NHS Trust, on **01752 763089 Monday – Friday 0900 – 1700 hours** **Out of those working hours** please call Cardiac Consultant via switchboard **01752 202082**.

References:

8. Procedure for the removal of implantable cardioverter defibrillators from deceased patients prior to cremation, Procedure 5020, (2004) University Hospitals Plymouth NHS Trust.

Consultation documents:

9. Braun, T.C. et al. (1999) Cardiac pacemakers and implanted defibrillators in terminal care, *Journal of Pain and Symptom Management*, 18(2): 126-3
10. British Heart Foundation (2007) Implantable cardioverter defibrillators in patients who are reaching the end of life, a discussion document for health professionals
11. Mueller, P.S. et al (2003) Ethical analysis of withdrawal of pacemaker or implantable cardioverter defibrillator support at the end of life, *Mayo Clinic proceedings*, 78: 959 – 963
12. Sears, S.F., Vazquez, Sowell, L., Kuhl, E.A. et al (2006) Quality of death: Implantable cardioverter defibrillators and proactive care, *Pace*, 29:637-42

Introduction

Facing death and the associated pain of loss and separation may be the most challenging of all human experience. Everyone is unique, should be treated with dignity and respect, and a person-centred approach to care takes into account physical, psychological, social and spiritual needs along life's journey. These layers make the whole person and are the key elements of holistic care. The valuable holistic contribution of inner well-being to physical health is well-documented for all involved in the patient journey and is an increasingly important and developing tool for all areas of healthcare.

Spirituality may be defined as the search or process of reflection, a growing self-awareness, in trying to come to terms with or make sense of one's own situation. Spiritual care means supporting people in this process as they grow to see and express hopes and fears, and find coping mechanisms to find inner well-being. There may, or may not, be a sense of 'otherness' or search for God, meaning that for *some* their spirituality may link with his/her faith in a religion and for many it may not. Even a simple spiritual assessment is essential in holistic care provision together with understanding the difference between spiritual care and the provision of religious needs.

Religion may be defined as a set of beliefs and practices in a God/or gods, and each major religion has different interpretations. For patients with a faith in a religion, staff should make every effort to record a patient's religious affiliation, mindful of the patient's right to refuse to provide it. This may be especially helpful where 'end-of-life-ritual' support may be required.

Religious practices may be part of the patient's daily routine, or become more important in illness, or when 'end of life' issues develop. Detailed information of the essential expectations from all the major groups can be found on University Hospitals Plymouth NHS Trust Staffnet using this link [World Faith A-Z](#) or following this route.

Staffnet -> Depts -> Other Support -> Pastoral & Spiritual -> World Faith A-Z

Chaplains have a particular role in providing and facilitating skills in spiritual care and work generically for everyone, people of every faith and of none. The breadth of the chaplain's role should be understood as a pastoral, spiritual, ethical and religious resource in terms of practice, consultancy and teaching. They are recognized as part of the multidisciplinary team.

A chaplain is available 24hrs a day, contactable via switchboard, and here for everyone, to offer a listening ear, help people make sense of their situation, and, *only if desired*, can provide faith support from all major religions. The chaplains should always be the first point of contact when looking for faith representatives.

The Chapel is on Level 7 and open all the time. The Multi Faith Prayer Room is also there, within the department offices, although out-of-hours access is via the porters' lodge.

Don't feel you're alone in caring for the whole person!

Chaplains *are* available 24/7 as lead in advising in these 'end-of-life areas' and in any pastoral/spiritual care for patients, staff, relatives and visitors.

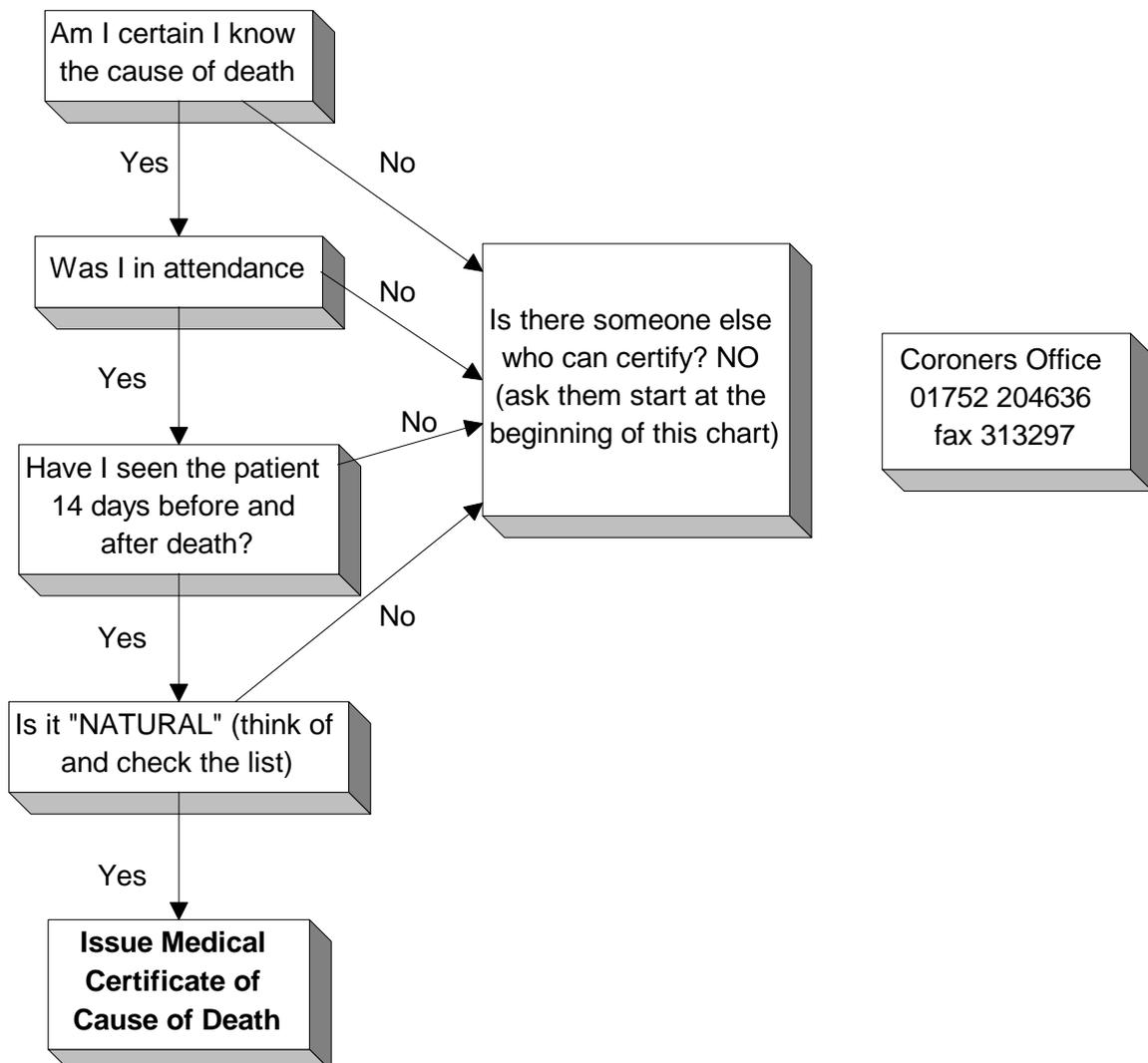
At any time, day or night, please call switchboard and ask them to page the on-call chaplain.

Death must be verified by a medical practitioner. Doctors need to be mindful that the relatives of the deceased may well wish to meet with them to discuss the patient's death and its cause.

A medical certificate of the cause of death and cremation form Part 4 must be completed by a medical practitioner who has treated the patient prior to their death. **This must be done as soon as possible after death – and no later than the next working day.**

When preparing to complete the medical certificate, the following flow-chart should be used to guide the decision-making process of the doctor:

Can I issue a Medical Certificate of the Cause of Death and a Cremation form?



N.B. If there are any doubts on the completion of a medical certificate of death or a cremation form, the doctor should contact the Coroner's office on x39679/81.

The personal contact details of the doctor completing the forms must be entered on the medical certificate, including details of GMC number, qualifications and printed name – as the Bereavement office, Coroner or Medical Referee may need to make contact to discuss the certificate urgently.

Check list for referral to Coroner's Officer

- The cause of death is unknown
- It cannot readily be certified as being due to natural causes.
- The deceased was not attended by the doctor during his last illness or was not seen within the last 14 days or viewed after death
- There are any suspicious circumstances or history of violence
- The death may be linked to an accident (whenever it occurred) or a fall
- There is any question of self-neglect or neglect by others
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station)
- The deceased was detained under the Mental Health Act
- The death is linked with an abortion
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self-injury or overdose)
- The death could be due to industrial disease or related in any way to the deceased's employment. See the long check list in the Medical Cause of Death Certificate book
- The death is due to a hospital acquired infection
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should be referred)
- The death may be related to a medical procedure or treatment whether invasive or not within the last 12 months
- There are concerns that the death may be due to lack of medical care
- There are any other unusual or disturbing features to the case
- The death occurs after admission to hospital within 24 hours
- It may be wise to report any death where there is an allegation of medical mismanagement.

This note is for guidance only. If in any doubt contact the Coroner's Officers for further advice.

Administrative Procedural Note Hospital Bereavements

Relevant to: - All ward administrators and ward based staff.

Purpose of Procedure: (to include the implications of not following the process).

To ensure that the correct procedure is in place and adhered to at all times. This will assist all parties that may be involved in the bereavement process. This will include bereavement officers, ward administrators, mortuary staff, consultants and the coroner's officers.

Following this process will assist relatives in the bereavement process and alleviate unnecessary anxiety at a difficult time.

Process to follow:

1. As soon as the ward administrator arrives on duty he / she should check to see if there have been any deaths.
2. Ensure iPM is updated with the accurate date and time of death.
3. Inform the junior doctor(s) or the doctor during attendance to the deceased that the patient has died **as soon as they arrive on duty, before starting their ward rounds.**
4. Advise the doctor that completion of the certificate is urgent and stress the need that this is done as soon as possible, to lessen stress for bereaved families.
5. The ward administrator must telephone the GP and inform him / her of the death as soon as possible after the death.
6. Ward administrator must keep the Bereavement Team informed of any delays.
7. **Casenotes must be tidied before being delivered to the Bereavement Office.**
8. Check valuables have been listed correctly i.e. valuables entered on to a separate sheet in the property book.
9. Once the certificate is complete, check the doctor has printed his name clearly under his signature – in order for the registration to proceed the doctor's name must be legible, with details of GMC number and qualifications. **Ensure the doctor has completed a cremation form at the same time.**
10. Deliver the certificate to the Bereavement Office as quickly as possible, proceed as follows:
 1. Certificate with tidied casenotes
 2. Property book with non-valuable property i.e. clothes etc. Any soiled clothes or personal items are to be retained on the ward.
 3. Valuables (listed separately) to the cashier

11. The Bereavement Office will retain the casenotes, certificate and non-valuable property.

12. Property and property book

A) Non-valuable property can be handed over to relatives on the ward once they have signed the receipt on the green copy in the property book. *This procedure is encouraged in order to save the Ward Administrator carrying the property some distance to the Bereavement Office.*

B) Remove – white copy

This must be kept with the non-valuable, or valuable property – as this is the relative's copy.

Non-valuable property is kept in the Bereavement Office.

Valuable property is taken to the Cashier's Office.

Green copy

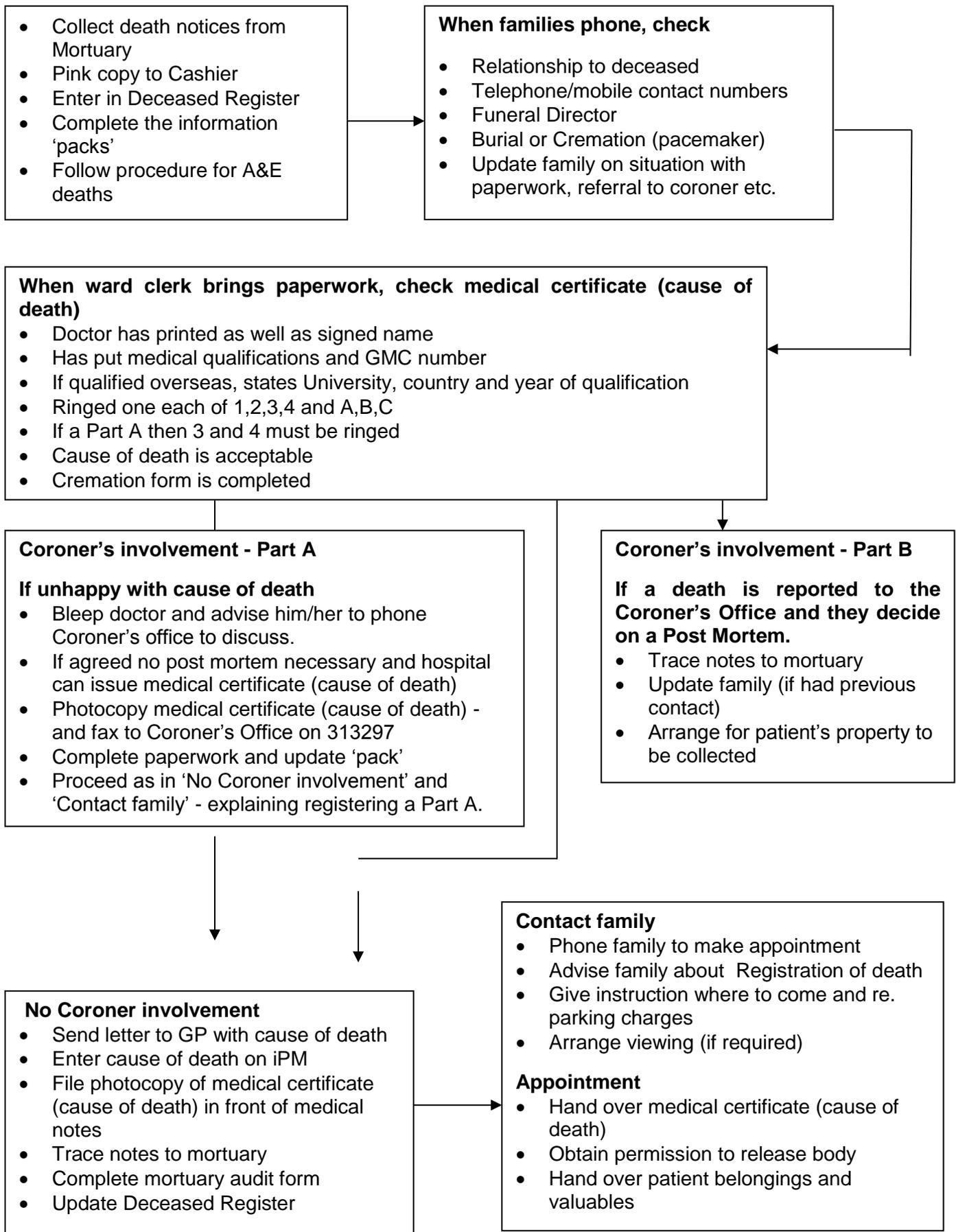
Relatives will sign the green form as a way of receipt when they receive the property.

- *Non-valuable property* – the Bereavement Office will sign the green copy, by way of acknowledgement of receiving the non-valuable property. It will then be removed from the book and retained by the office with the property.
- *Valuable property* – the cashier will check the valuables against the green form. The cashier will only acknowledge this if the valuables are entered correctly. After this, procedure is the same as with the bereavement officer.

- The ward administrator will then return to the ward with the property book.

Useful Contacts

Bereavement Office	39492 or 39473
PALS	39884



The removal of endotracheal tubes after death is a contentious issue. A conflict arises because in order to determine cause of death the Coroner requires a maximum amount of information which could require the endotracheal tube being left in situ. However, clinicians frequently want to remove the tubes, to limit distress to the relatives who view the body. In an effort to resolve this, a meeting was held involving all interested parties to identify a way forward.

Failure to correctly place an endotracheal tube is rapidly fatal thus in any patient who has an endotracheal tube in situ for some time prior to death, it can be assumed that the endotracheal tube was correctly placed and thus can be removed, although it is essential that correct placement is **confirmed in writing in the patients notes**.

In any patient where correct placement is uncertain then the endotracheal tube must be left in situ, if an endotracheal tube is placed during an active resuscitation, which the patient does not survive then the endotracheal tube may only be removed if there is clear evidence that it was correctly placed i.e.

1. Radiographic (C X R, CT etc)
2. A sequence of blood gases which demonstrate gas exchange
3. An End tidal Co2 trace for greater than 3 minutes
4. Auscultation of breath sounds
5. Bronchoscopy

If the endotracheal tube is removed then **confirming evidence must be documented** in the patient's notes by the most senior clinician present who was not intimately involved in placing the endotracheal tube.

The purpose of this document is to provide all staff working with the Bereavement Team with the essential knowledge or the process for sending out bereavement cards.

Stage 1 – Identification of deceased

- i. Notification of death is received in the Bereavement Office – delivered by the Mortuary Team
- ii. Complete usual process for managing the Bereavement Process.
- iii. Meet with family and deliver the Medical Cause of Death Certificate.

Stage 2 – Identify cards to be sent

- i. Next of Kin details recorded on the bereavement register in (column M) following meeting with the family
- ii. Review the bereavement register to establish those families who are eligible to receive a bereavement card. – need to check for complaints and other ongoing investigations.
- iii. Check existing complaints and incidents. Paste the list of patients into an email and send to the Complaints and PALS mailboxes. The Bereavement Team are responsible for reviewing the incident log.
- iv. Where a complaint, PALS enquiry or Incident has taken place and the Trust is already in contact with the family or duty of candour has been applied a card is NOT SENT.
- v. The register should be updated and the “card sent” column marked with a N to clearly show a card is not required.

Stage 3 – Send the card and update records

- i. Critical Care independently send their own cards to families and therefore the bereavement team are not required to undertake this task.
- ii. Once the reviewed list of patients has been completed, where it has been identified as appropriate to send a bereavement card the patient should be highlighted in yellow on the bereavement register for easy identification purposes for the bereavement team.
- iii. Once the necessary checks have been completed, the cards are printed and sent to the Next of Kin detailed on the bereavement register. Cards to be sent one week after the meeting with next of kin is completed and certificate is provided, agreed this would take place once a week on Fridays.
- iv. The “card sent” column of the bereavement register (column X) must then be updated to Y.

Stage 4 – Contact from Next of Kin

- i. After the card has been sent and if contact is made by a family, this must be recorded on the bereavement register.
- ii. Bereavement team must make contact with the appropriate matron to inform them of the request and record the details on DATIX. All documents must be saved to the record and the bereavement register to be updated with the DATIX reference number.
- iii. Matron to send back to the bereavement team a record of the meeting and when this took place for the bereavement records to be updated.
- iv. Datix record closed including details of meeting and any actions taken.

Dissemination Plan			
Document Title	Care of the Deceased Patient Policy		
Date Finalised	July 2018		
Previous Documents			
Action to retrieve old copies	To be managed by the Information Governance Team.		
Dissemination Plan			
Recipient(s)	When	How	Responsibility
All Trust staff		Vital Signs	Information Governance Team
Patient Experience Committee	July 2018	Email	Patient Experience & Engagement Manager
All service lines management teams	July 2018	Email	Patient Experience Engagement & Manager

Review Checklist		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y
Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Y
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y

Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Core Information	
Date	July 2018
Title	Care of the Deceased Patient Policy
What are the aims, objectives & projected outcomes?	<p>To set out the Trust’s arrangements for the provision of the Bereavement Service, which is in place to provide information, guidance and support to our patients, bereaved relatives, carers and members of the public.</p> <p>To ensure that all staff who have significant contact with deceased patients and their families have access to policies / procedures to enable them to provide appropriately high standards of care.</p>
Scope of the assessment	
Collecting data	
Race	There is no evidence to suggest that there is a negative impact on race regarding this policy. Policy can be made available in alternative languages.
Religion	This is mitigated as the Spiritual and Pastoral Care Team provide publish guidance on different religions.
Disability	There is no evidence to suggest that there is a negative impact on disability regarding this policy. Policy can be made available in alternative languages.
Sex	There is no evidence to suggest that there is a negative impact on gender regarding this policy.
Gender Identity	There is no evidence to suggest that there is a negative impact on gender identity regarding this policy. Currently data for this area is not collected due to the current provision on the data collection systems. However this is an areas that is under development.
Sexual Orientation	There is no evidence to suggest that there is a negative impact on sexual orientation regarding this policy. Currently data for this area is not collected due to the current provision on the data collection systems. However this is an areas that is under development.
Age	There is no evidence to suggest that there is a negative impact on age regarding this policy.
Socio-Economic	There is no evidence to suggest that there is a negative impact on socio-economic regarding this policy. Policy can be made available in alternative languages.
Human Rights	Data is currently monitored, analysed and published on the Trust website. Areas of concern will be addressed through appropriate action plans.
What are the overall trends/patterns in the above data?	<p>There are currently no trends or patterns in the data that is produced.</p> <p>Data is currently monitored and tracked through the existing bereavement contract. Areas of concern will be addressed through appropriate action plans.</p> <p>Consideration has been given to Coronial laws which were updated in April 2014 and the End of Life Care Guidance.</p>

Involving and consulting stakeholders				
Internal involvement and consultation	The policy has been reviewed and compiled by the Patient Experience & Engagement Lead and Head of Spiritual & Pastoral Care. The policy has been circulated to the Patient Experience Committee and Matrons for consultation.			
External involvement and consultation	The policy has been developed in line with the coronial laws and end of life care guidance. Representatives from Plymouth and Cornwall Healthwatches have been consulted through the Patient Experience Committee.			
Impact Assessment				
Overall assessment and analysis of the evidence	<p>This impact assessment has shown there could be an impact on patients from different religious backgrounds. However this document provides guidance on differing religions and is also available in other formats and languages if required.</p> <p>Data is currently monitored, analysed as part of the bereavement contract for funerals. No areas of concern were identified.</p>			
Action Plan				
Action	Owner	Risks	Completion Date	Progress update
Specific issues and data gaps that may need to be addressed through consultation or further research	None identified.			